CHAPTER II

PROVIDER PARTICIPATION REQUIREMENTS

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PARTICIPATING PROVIDER

A participating provider is an agency, program, or person that meets the standards and requirements set forth by the Department of Medical Assistance Services (DMAS) and that has a current, signed Participation Agreement with DMAS.

MEDICAID PROGRAM INFORMATION

Federal regulations governing program operations require Virginia Medicaid to supply program information to all providers. The current system for distributing this information is keyed to the provider number on the enrollment file, which means that each assigned provider receives program information. Providers enrolled at multiple locations or who are a member of a group using one central office may receive multiple copies of manuals, updates, and other publications sent by DMAS. Individual providers may request that publications not be mailed to them by completing a written request to the First Health/Provider Enrollment Unit (FH/PEU) at the address given under "Provider Enrollment" below.

PROVIDER ENROLLMENT

Any provider of services must be enrolled in the Medicaid/FAMIS programs prior to billing for any services provided to Medicaid/FAMIS clients. A copy of the provider agreement with instructions on how to complete the forms can be found at the DMAS website, www.dmas.virginia.gov or by calling the Provider Enrollment Unit at 1-888-829-5373 (in state, toll-free), 1-804-270-5105 (Richmond area and out-of-state long distance), or via fax at 1-804-270-7027. All providers must sign and complete the entire application and submit it to the Provider Enrollment/Certification Unit at:

First Health
VMAP-PEU
P.O. Box 26803
Richmond, Virginia 23261-6803

An original signature of every individual provider is required. The Medicaid Participation Agreement may be time-limited depending on the licensing required. All participating Medicaid providers are required to complete a new application and agreement as a result of any name change or change of ownership.

Upon receipt of the above information, a Medicaid identification number is assigned to each approved provider. This number must be used on all claims and correspondence submitted to Medicaid.

This manual contains instructions for billing and specific details concerning the Medicaid

Program. Providers must comply with all sections of this manual to maintain continuous participation in the Medicaid Program.

PARTICIPATION REQUIREMENTS

All providers enrolled in the Virginia Medicaid Program must adhere to the conditions of participation outlined in their Participation Agreements. Providers approved for participation in the Medicaid Program must perform the following activities as well as any others specified by DMAS:

- Immediately notify FH/PEU, in writing whenever there is a change in the information that the provider previously submitted. For a change of address, notify FH/PEU prior to the change and include the effective date of the change;

- Assure freedom of choice to recipients in seeking medical care from any institution, pharmacy, or practitioner qualified to perform the service(s) required and participating in the Medicaid Program at the time the service is performed;

- Assure the recipient's freedom to reject medical care and treatment;

- Comply with Title VI of the Civil Rights Act of 1964, as amended (42 U.S.C. §§ 2000d through 2000d-4a), which requires that no person be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance on the grounds of race, color, or national origin;

- Provide services, goods, and supplies to recipients in full compliance with the requirements of the Rehabilitation Act of 1973, as amended (29 U.S.C. § 794), which states that no otherwise qualified individual with a disability shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance. The Act requires reasonable accommodations for certain persons with disabilities;

- Provide services and supplies to recipients of the same quality and in the same mode of delivery as provided to the general public;

- Charge DMAS for the provision of services and supplies to recipients in amounts not to exceed the provider's usual and customary charges to the general public;

- Accept as payment in full the amount reimbursed by DMAS. 42 CFR § 447.15 provides that a "State Plan must provide that the Medicaid agency must limit participation in the Medicaid Program to providers who accept, as payment in full, the amount paid by the agency ...." The provider should not attempt to collect from the recipient or the recipient's responsible relative(s) any amount that exceeds the usual Medicaid allowance for the service rendered. For example: If a third-party payer reimburses $5.00 of an $8.00 charge, and Medicaid's allowance is $5.00, the provider may not attempt to collect the $3.00 difference from Medicaid, the

recipient, a spouse, or a responsible relative. The provider may not charge DMAS or a recipient for broken or missed appointments;

- Accept assignment of Medicare benefits for eligible Medicaid recipients;
- Use Medicaid Program-designated billing forms for submission of charges;
- Maintain and retain business and professional records that document fully and accurately the nature, scope, and details of the health care provided;
- In general, such records must be retained for a period of at least five years from the date of service or as provided by applicable state laws, whichever period is longer. However, if an audit is initiated within the required retention period, the records must be retained until the audit is completed and every exception resolved;
- Furnish to authorized state and federal personnel, in the form and manner requested, access to records and facilities;
- Disclose, as requested by DMAS, all financial, beneficial, ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions, or other legal entities providing any form of health care services to Medicaid recipients; and
- Hold information regarding recipients confidential. A provider shall disclose information in his/her possession only when the information is used in conjunction with a claim for health benefits or the data is necessary for the functioning of the state agency. DMAS shall not disclose medical information to the public.

PROVIDER QUALIFICATIONS

To qualify as a DMAS provider of selected mental health, case management, and substance abuse services, the provider of the services must meet the following criteria:

- The provider must have the administrative and financial management capacity to meet state and federal requirements; and
- The provider must have the ability to document and maintain individual case records in accordance with state and federal requirements.

In addition to the criteria stated above, a provider must meet the following requirements:

Mental Health

The following licenses are consistent with new Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS) licensing regulations, effective September 2002. The new license is required when DMHMRSAS licenses are renewed.

- Intensive In-Home Services providers for children and adolescents must be licensed as a provider of Intensive In-Home Services by DMHMRSAS;
- Therapeutic Day Treatment providers for children and adolescents must be licensed as a provider of Day Treatment Services by DMHMRSAS. The minimum staff-to-youth ratio shall ensure that adequate staff is available to meet the needs of the youth identified on the Individualized Service Plan (ISP);
- Day Treatment/Partial Hospitalization providers must be licensed as a provider of Day Treatment Services by DMHMRSAS;
- Psychosocial Rehabilitation providers must be licensed as a provider of Psychosocial Rehabilitation or Clubhouse Services by DMHMRSAS;
- Crisis Intervention providers must be licensed as a provider of Outpatient Services by DMHMRSAS;
- Intensive Community Treatment providers must be licensed by DMHMRSAS as a provider of Intensive Community Treatment or a Program of Assertive Community Treatment;
- Crisis Stabilization providers must be licensed by DMHMRSAS as a provider of Outpatient Services; and
- Mental Health Support Services providers must be licensed by DMHMRSAS as a provider of Supportive In-Home Services, Intensive Community Treatment, or as a program of Assertive Community Treatment.

Community-Based Residential Services for Children and Adolescents under 21 (Level A)

- Providers must be licensed by the Department of Social Services (DSS), Department of Juvenile Justice (DJJ), or Department of Education (DOE) under the Standards for Interdepartmental Regulation of Children's Residential Facilities;
- At least 50% of the direct care staff must meet DMAS paraprofessional staff criteria; and
- The program director supervising the program/group home must be, at a minimum, a qualified mental health professional (QMHP) with a bachelor's degree and have at least one year of direct work with mental health clients. The program director must

be employed full time.

Therapeutic Behavioral Services (Level B)

- Providers must be licensed by DMHMRSAS under the Standards for Interdepartmental Regulation of Children's Residential Facilities;

- At least 50% of the direct care staff must meet DMAS paraprofessional staff criteria. The clinical director must be a licensed mental health professional (LMHP). The caseload of the clinical director must not exceed 16 clients including all sites for which the clinical director is responsible; and

- The program director must be full time and be a QMHP with a bachelor's degree and at least one year's clinical experience.

If any services are subcontracted, the subcontracted provider must meet the same qualifications as listed in this chapter for program operation and provider qualifications.

"Licensed mental health professional (LMHP)" refers to a physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, licensed marriage and family therapist, or a psychiatric clinical nurse specialist. If psychotherapy is to be billed by the LMHP, the therapist must comply with the outpatient psychotherapy criteria outlined in Chapters II, VI, V, and VI of the *Psychiatric Services* Provider Manual.

"Qualified mental health professional (QMHP)" refers to a clinician in the human services field who is trained and experienced in providing psychiatric or mental health services to individuals who have a psychiatric diagnosis. In the Commonwealth of Virginia, authorized professionals and minimal qualifications for a QMHP are as follows:

1. Physician: a doctor of medicine or osteopathy licensed in Virginia;

2. Psychiatrist: a doctor of medicine or osteopathy, specializing in psychiatry and licensed in Virginia;

3. Psychologist: an individual with a master's degree in psychology from an accredited college or university with at least one year of clinical experience;

4. Social worker: an individual with a master's or bachelor's degree from a school of social work accredited or approved by the Council on Social Work Education with at least one year of clinical experience;

5. Registered nurse (RN): a registered nurse licensed in Virginia with at least one year of clinical experience;

6. Mental Health Worker:

   - an individual with a bachelor's degree in human services, a related field, or other degree deemed equivalent to those described, from an accredited college and with at least one year of clinical experience; OR

   - a Registered Psychiatric Rehabilitation Provider (RPRP) registered with the International Association of Psychosocial Rehabilitation Services (IAPSRS) as of January 1, 2001; OR

   - an individual with at least a bachelor's degree from an accredited college in an unrelated field with an associate's degree in a human services field and who has at least three years' clinical experience; OR

   - an individual with at a least bachelor's degree from an accredited college and certification from the International Association of Psychosocial Rehabilitation Services (IAPSRS) as a Certified Psychiatric Rehabilitation Practitioner (CPRP); OR

   - an individual with at least a bachelor's degree from an accredited college in an unrelated field that includes at least 15 semester credits (or equivalent) in a human services field and who has at least three years' clinical experience; OR

   - four years' clinical experience working directly with individuals with mental illness or mental retardation.

Clinical experience means providing direct services to individuals with mental illness, mental retardation, or receiving gerontology or special education services. It includes supervised internships, practicums, and field experience.

A human services field includes social work, gerontology, psychology, psychiatric rehabilitation, special education, sociology, counseling, vocational rehabilitation, and human services counseling.

Note: If the QMHP is one of the defined LMHPs, the QMHP may perform the services designated for the LMHPs unless it is specifically prohibited.

Paraprofessionals in mental health must, at a minimum, meet one of the following criteria:

1. Be registered with the International Association of Psychosocial Rehabilitation Services (IAPSRS) as an Associate Psychiatric Rehabilitation Provider (APRP) as of January 1, 2001.

2. An associate's degree in a related field (social work, psychology, psychiatric rehabilitation, sociology, counseling, vocational rehabilitation, human services, Community Mental Health Rehabilitative Services counseling) and at least one year of experience providing direct services to persons with a diagnosis of mental illness or gerontology and special education.

3. An associate's degree, or higher degree, in an unrelated field and at least three years' experience providing direct services to persons with a diagnosis of mental illness or gerontology clients or special education clients.

4. A minimum of 90 hours of classroom training and 12 weeks of experience under the direct personal supervision of a QMHP providing services to persons with mental illness and at least one year of experience (including the 12 weeks of supervised experience). Direct personal supervision means that the QMHP is on-site at all times and countersigns all documentation. Please refer to the "Exhibits" section at the end of this chapter for the 90-hour training program for paraprofessionals.

5. College credits (from an accredited college) earned toward a bachelor's degree in a human service or related field (social work, gerontology, psychology, psychiatric rehabilitation, special education, sociology, counseling, vocational rehabilitation, and human services counseling) that are equivalent to an associate's degree will be accepted to meet the educational requirements. One year of clinical experience is also required. The experience may include supervised internships, practicums, and field experience.

6. Licensed Practical Nurse (LPN): licensed by the Commonwealth of Virginia and with at least one year of clinical experience. The clinical experience may include supervised internships, practicums, and field experience.

7. Certification from the International Association of Psychosocial Rehabilitation Services (IAPSRS) as a Certified Psychiatric Rehabilitation Practitioner (CPRP).

A Certified Pre-screener is an employee of the local Community Services Board (CSB) or its designee, who is skilled in the assessment and treatment of mental illness and has completed a certification program approved by DMHMRSAS.

Substance Abuse Services

- Residential Treatment programs for pregnant and postpartum women shall be licensed by DMHMRSAS to provide Residential Substance Abuse Services.

- Day Treatment programs for pregnant and postpartum women must be licensed by DMHMRSAS to provide Outpatient Services or Substance Abuse Day Treatment Services.

A Qualified Substance Abuse Professional must be one of the following:

- A counselor who has completed master's level training in psychology, social work, counseling, or rehabilitation; who is also either certified as a substance abuse counselor by the Board of Licensed Professional Counselors, Marriage and Family Therapists, and Substance Abuse Treatment Professionals, or as a certified addictions counselor by the Substance Abuse Certification Alliance of Virginia, or who holds any certification from the National Association of Alcoholism and Drug Abuse Counselors.

- A professional licensed by the appropriate board of the Virginia Department of Health Professions as either a professional counselor, clinical social worker, RN, clinical psychologist, or physician who demonstrates competencies in all of the following areas of addiction counseling: clinical evaluation; treatment planning; referral; service coordination; counseling; client, family, and community education; documentation; professional and ethical responsibilities; or as a licensed substance abuse professional.

- A professional certified as either a clinical supervisor by the Substance Abuse Certification Alliance of Virginia or as a master education counselor by the National Association of Alcoholism and Drug Abuse Counselors.

Mental Health Case Management

There shall be no restriction on an individual's free choice of case management providers or other mental health or medical services providers. The mental health case management provider must be a Community Services Board (CSB) member and licensed by DMHMRSAS.

To qualify as a provider of services through DMAS for Rehabilitative Mental Health Case Management for adults with serious mental illness and children and adolescents with serious emotional disturbance, the provider must meet the following criteria:

- The provider must have the administrative and financial management capacity to meet state and federal requirements;

- The provider must have the ability to document and maintain individual case records in accordance with state and federal requirements;

- The services shall be in accordance with the *Virginia Comprehensive State Plan for Mental Health, Mental Retardation, and Substance Abuse Services*; and

- The provider must be licensed as a provider of Case Management Services by DMHMRSAS.

Providers may bill Medicaid for mental health case management only when the services are provided by qualified mental health case managers. Persons providing case management services must have knowledge of:

- Services, systems, and programs available in the community including primary health care, support services, eligibility criteria and intake processes, generic community resources, and mental health, mental retardation, and substance abuse treatment programs;

- The nature of serious mental illness, mental retardation, and substance abuse depending on the population served, including clinical and developmental issues;

- Different types of assessments, including functional assessments, and their uses in service planning;

- Treatment modalities and intervention techniques, such as behavior management, independent living skills training, supportive counseling, family education, crisis intervention, discharge planning, and service coordination;

- The service planning process and major components of a service plan;

- The use of medications in the care or treatment of the population served; and

- All applicable federal and state laws, regulations, and local ordinances.

Persons providing case management services must have skills in:

- Identifying and documenting an individual's needs for resources, services, and other supports;

- Using information from assessments, evaluations, observation, and interviews to develop ISPs;

- Identifying services and resources within the community and establishing service systems to meet the individual's needs and documenting how resources, services, and natural supports, such as family, can be utilized to achieve an individual's personal habilitative, rehabilitative, and life goals; and

- Coordinating the provision of services by public and private providers.

Persons providing case management services must have abilities to:

- Work with team members, maintaining effective inter- and intra-agency working relationships;
- Work independently, performing position duties under general supervision; and
- Engage and sustain ongoing relationships with individuals receiving services.

The provider must be a DMHMRSAS-licensed case management provider, and case management must be provided by a qualified mental health case manager as defined above.

The individual providing case management services is not required to be a member of an organizational unit that provides only case management. The case manager who is not a member of an organized case management unit must possess a job description that describes case management activities as job duties, must provide services as defined for case management, and must comply with service expectations and documentation requirements as required for organized case management units.

REQUIREMENTS OF SECTION 504 OF THE REHABILITATION ACT

Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. § 794), provides that no individual with a disability shall, solely by reason of the disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal assistance. As a condition of participation, each Medicaid provider has the responsibility for making provisions for individuals with disabilities in the provider's programs or activities.

In the event a discrimination complaint is lodged, DMAS is required to provide to the Office of Civil Rights (OCR) any evidence regarding compliance with these requirements.

UTILIZATION OF INSURANCE BENEFITS

The Virginia Medical Assistance Program is a "last pay" program. Benefits available under Medical assistance shall be reduced to the extent that they are available through other federal, state, or local programs, other insurance, or third party liability. Health, hospital, Workers' Compensation, or accident insurance benefits shall be used to the fullest extent in meeting the medical needs of the covered person. Supplementation of available benefits shall be as follows:

- **Title XVIII (Medicare)** - Virginia Medicaid will pay the amount of any deductible or co-insurance for covered health care benefits under Title XVIII of the Social Security Act for all eligible persons covered by Medicare and Medicaid.
- **Workers' Compensation** - No Medicaid Program payments shall be made for a patient covered by Workers' Compensation.
- **Other Health Insurance** - When a consumer has other health insurance (such as CHAMPUS/TRICARE, Blue Cross-Blue Shield, or Medicare), Medicaid requires

that these benefits be used first. Supplementation shall be made by the Medicaid Program when necessary, but the combined total payment from all insurance shall not exceed the amount payable under Medicaid had there been no other insurance.

- **Liability Insurance for Accidental Injuries -** DMAS will seek repayment from any settlements or judgments in favor of Medicaid consumers who receive medical care as the result of the negligence of another. If a consumer is treated as the result of an accident and DMAS is billed for this treatment, Medicaid should be notified promptly so action can be initiated by Medicaid to establish any lien that may exist under § 8.01-66.9 of the Code of Virginia. In liability cases, providers may choose to bill the third-party carrier or file a lien in lieu of billing Medicaid.

- If there is an accident in which there is a possibility of third-party liability or if the consumer reports a third-party responsibility (other than those cited on his or her Medical Assistance Identification Card), and whether or not Medicaid is billed by the provider for rendered services related to the accident, the provider must forward the DMAS-1000 form to the attention of the Third Party Liability Unit, DMAS, 600 East Broad Street, Richmond, Virginia 23219. (To obtain a copy of this form, see the "Replenishment of Billing Materials" section in Chapter V of this manual.)

TERMINATION OF PROVIDER PARTICIPATION

A participating provider may terminate participation in Medicaid at any time; however, written notification must be provided to the DMAS Director and FH-PEU 30 days prior to the effective date. The addresses are:

Director
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

First Health –VMAP-PEU
P.O. Box 26803
Richmond, VA 23261-6803

DMAS may terminate a provider from participating upon 30 days' written notification prior to the effective date. Such action precludes further payment by DMAS for services provided to customers subsequent to the date specified in the termination notice.

TERMINATION OF A PROVIDER CONTRACT UPON CONVICTION OF A FELONY

Section 32.1-325 D.2 of the Code of Virginia mandates that "Any such Medicaid agreement or contract shall terminate upon conviction of the provider of a felony." A provider convicted of a felony in Virginia or in any other of the 50 states must, within 30 days, notify DMAS of this conviction and relinquish the agreement. Reinstatement will be contingent upon provisions of state law.

RECONSIDERATION AND APPEALS OF ADVERSE ACTIONS

Non-State-Operated Provider

The following procedures will be available to all non-state-operated providers when DMAS takes adverse action.

The reconsideration and appeals process will consist of three phases: a written response and reconsideration of the preliminary findings, the informal conference, and the formal evidentiary hearing. The provider will have 30 days to submit information for written reconsideration. The provider has the right to appeal the reconsideration decision by requesting an informal fact finding conference within 30 days of receipt of the written notification of the reconsideration decision. The provider must submit a detailed statement of the factual and legal basis for each item under appeal. The notice of appeal and supporting documentation shall be sent to:

Director, Division of Appeals
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

If the denial is upheld, the provider has the right to appeal the informal fact finding decision by requesting a formal evidentiary appeal within 30 days of written notification of the informal fact finding decision. The notice of appeal and supporting documentation shall be sent to:

Director, Division of Appeals
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

An appeal of adverse actions concerning provider reimbursement shall be heard in accordance with the Administrative Process Act (§ 2.2-4000 et seq.) of the Code of Virginia (the APA) and the *State Plan for Medical Assistance* provided for in § 32.1-325 of the Code of Virginia. Court review of final agency determinations concerning provider reimbursement shall be made in accordance with the APA.

Any legal representative of a provider must be duly licensed to practice law in the Commonwealth of Virginia.

State-Operated Provider

The following procedures will be available to state-operated providers when DMAS takes adverse action, such as termination or suspension of the provider agreement or denial of payment for services rendered based on utilization review decisions. A state-operated provider is a provider of Medicaid services enrolled in the Medicaid Program operated by the Commonwealth of Virginia.

A state-operated provider has the right to request a reconsideration for any issue which would be otherwise administratively appealable under the State Plan by a non-state-operated provider.

This is the sole procedure available to state-operated providers.

The reconsideration and appeals process will consist of three phases: an informal review by the Division Director, review by the Director of DMAS, and Secretarial review. First, the state-operated provider must submit written information to the appropriate DMAS Division specifying the nature of the dispute and the relief sought. This request must be received by DMAS within 30 calendar days after the provider receives its Notice of Amount of Program Reimbursement, Notice of Proposed Action, findings letter, or other DMAS notice giving rise to a dispute. If a reimbursement adjustment is sought, the written information must include the nature of the adjustment sought; the amount of the adjustment sought; and the reasons for seeking the adjustment. The Division Director or his/her designee will review this information, requesting additional information as necessary. If either party so requests, they may meet to discuss a resolution. Any designee shall then recommend to the Division Director whether relief is appropriate in accordance with applicable laws and regulations. The Division Director will consider any recommendation of his/her designee and render a decision.

A state-operated provider may, within 30 days after receiving the Division Director's informal review decision, request that the DMAS Director or his designee review the decision of the Division Director. The DMAS Director has the authority to take whatever measures he/she deems appropriate to resolve the dispute.

If the preceding steps do not resolve the dispute to the satisfaction of the state-operated provider, within 30 days after receipt of the decision of the DMAS Director, the provider may request the DMAS Director to refer the matter to the Secretary of Health and Human Resources or any other Cabinet Secretary as appropriate. Any determination by such Secretary or Secretaries will be final.

REPAYMENT OF IDENTIFIED OVERPAYMENTS

Pursuant to Section 32.1-325.1 of the Code of Virginia, DMAS is required to collect identified overpayments. Repayment must be made on demand unless a repayment schedule is agreed to by DMAS. When a lump-sum cash payment is not made, interest will be added on the declining balance at the statutory rate, pursuant to Section 32.1-313.1 of the Code of Virginia. Repayment and interest will not apply pending appeal. Repayment schedules must ensure full repayment within 12 months unless the provider demonstrates, to the satisfaction of DMAS, a financial hardship warranting extended repayment terms.

EXHIBITS

VIRGINIA

Department of Medical Assistance Services
600 East Broad Street
Suite 1300
Richmond, Virginia
23219

THIRD PARTY LIABILITY INFORMATION REPORT

(FOR MEDICAID PROVIDERS' USE)

This form MUST be submitted to the Department of Medical Assistance Services within 30 days after a service is rendered to a Virginia Medicaid recipient for the treatment of accident related injuries. Federal Regulations (42CFR - 433.138) require the Department of Medical Assistance Services to exert positive efforts toward locating liable third parties and to diligently seek refunds of applicable liability payments. Please complete this form to the best of your knowledge to assist us in this effort. Statutory authority is provided for full recovery of funds from liable third parties in Section 8.01-66.9 of the Code of Virginia.

PLEASE TYPE OR PRINT

NAME OF RECIPIENT: _____
(LAST) (FIRST) (MI)

RECIPIENT'S ELIGIBILITY NO. _____ DATE OF INJURY _____

TYPE OF ACCIDENT _____ DATE YOUR SERVICE BEGAN _____
(WORK, AUTO, HOME, GUNSHOT, ETC.)

NAME OF ATTORNEY _____

ADDRESS _____

(IF RECIPIENT HAS AN ATTORNEY, THE FOLLOWING INFORMATION IS NOT NEEDED.)

NAME OF INSURANCE COMPANY _____

ADDRESS _____

NAME OF INSURED PERSON _____

POLICY NO. _____ CLAIM NO. _____

COMMENTS _____

_____

_____

DIAGNOSIS _____ NAME OF PROVIDER _____

IS TREATMENT COMPLETED _____ YES _____ NO

DATE _____ BY _____

Providers will not be involved in litigation or collection attempts by the Department of Medical Assistance Services nor will reimbursement to the provider be withheld as a result of submitting this form.

PLEASE MAIL TO:

THIRD PARTY LIABILITY/CASUALTY
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
600 E. BROAD STREET, SUITE 1300
RICHMOND, VIRGINIA 23219

DMAS - 1000 R9/87

First Health Services Corporation

MAILING SUSPENSION REQUEST
SERVICE CENTER AUTHORIZATION
SIGNATURE WAIVER
PHARMACY POINT-OF-SALE

Please review and check the blocks which pertain to you:

- ☐ **MAILING SUSPENSION REQUEST:**
  I do not wish to receive Medicaid memos, forms, or manual updates under the Medicaid provider number given below.

- ☐ **COMPUTER GENERATED CLAIMS:**
  I certify that I have authorized the following service center to submit computer-generated invoices (by modem, diskette or tape) to Virginia Medicaid:

  _____
  (Service Center Preparing Invoices)

  Service center code: _____ **Magnetic Tape RA:** YES NO (Circle One)

  Prior service center code: _____

- ☐ **SIGNATURE WAIVER:**
  I certify that I have authorized submission of claims to Virginia Medicaid which contain my typed, computer generated, or stamped signature.

- ☐ **PHARMACY POINT-OF-SALE AUTHORIZATION (in-state providers only):**
  I wish to submit Point-of-Sale billings to Virginia Medicaid.

I understand that I am responsible for the information presented on these invoices and that the information is true, accurate, and complete. I further understand that payment and satisfaction of these claims will be from federal and state funds and that false claims, statements, documents, or concealment of material facts may be prosecuted under applicable federal and state laws.

PROVIDER NAME: _____

PROVIDER NUMBER: _____ Leave blank, if number pending.

SIGNATURE: _____

DATE: _____

TELEPHONE # _____

Please return completed form to:

First Health
VMAP-PEU
PO Box 26803
Richmond, Virginia 23261-6803
1-804-270-5105

90-HOUR TRAINING PROGRAM FOR PARAPROFESSIONAL STAFF

Introduction

Completion of this training program by employees of Virginia Community Services Boards (CSBs) will result in qualifying paraprofessionals as providers for Mental Health Rehabilitative Services. Programs of independent study will be documented and verified by the direct supervisor. Personnel records will document the overall successful completion of the employee's individual training program. Providers will either indicate that this model will be used or will submit an alternative model to DMAS.

Core Areas of Training

1) Orientation to Organization, Structure, Function, and Services of the CSB of employment. **8** hours

2) CPR and First-Aid. **8** hours

3) Management of Aggressive Behavior (such as Mandt, CPI, or a CSB program that is similar.) **8** hours

4) Universal Precautions/Blood-Borne Pathogens and Other Health-Related Concerns. **4** hours

5) Relationships, Boundaries, and Ethics: Professional Conduct and Behavior, Confidentiality. **8** hours

6) Working in the Larger Community: Resources and Referral Sources, Collaboration with Other Professionals, Using Self-Help and Advocacy Groups, Family Contacts. **4** hours

7) Basic Introduction to Psychopathology and Mental Illness Classification. **8** hours

8) Principles and Practices of the Primary Service Area of Employment: Psychosocial Rehabilitation, Support Services, Therapeutic Day Treatment for Children and Adolescents, and Day Treatment/Partial Hospitalization. Staff are required to complete this core element for each service in which they will work as a service provider. **8** hours per each service area.

9) Unique Characteristics of the Work Environment: Age-Specific, Physical Disabilities, Ethnic, and/or Cultural Issues of the Program's Participants. **4** hours

10) The Individualized Service Plan (ISP), Service Documentation and Review. **8** hours

11) Managing the Unexpected: Emergencies and Crisis Intervention,
Insuring the Safety of Self and Others. **4** hours

12) Psychotropic Medications and Side Effects. **4** hours

13) Provider-Specific Independent Study of Disorders, Service Populations, and Programs. **14** hours (This training component will allow providers to add other elements unique to their system or necessary for the individual's successful performance. Videotapes, assigned readings, and written reports can be used.)